



## BiB 1000 18 month questionnaire

*Hello my name is ..... from the Born in Bradford project. Thank you for agreeing for us to visit you again. We are very interested to know how things have been going since we last saw you. Babies grow so quickly, and change so much.*

*We are interested to know about what your baby is eating and how mealtimes are going. We also want to know if there have been any changes in your household and how you are feeling.*

*I will ask most of the questions but there are some sections of the questionnaire that I will ask you to complete yourself. I will be here to help you if you have any queries.*

*All the answers you give are confidential. Your name and address will not appear anywhere on the questionnaire.*

*We would be grateful if you would help us by answering as many of these questions as possible but if there are any questions you do not want to answer that is fine. There are no right or wrong answers.*

*Thank you for agreeing to answer these questions.*

**Administrative details**

Age of child (months) .....

Age of mother (years) .....

**What language was used for administering the questionnaire?**

- English    Mirpuri    Urdu    Other

**Mother's anthropometry**

Weight (kg)                      .                      Not able to take

**Baby's anthropometry**

Weight            (kg)                      .                      Not able to take

Length            (cm)                      .                      Not able to take

Head Circumference (cm)                      .                      Not able to take

Abdominal circumference (cm)                      .                      Not able to take

Triceps skinfold (mm)                      .                      Not able to take

Subscapular skinfold (mm)                      .                      Not able to take

Thigh skinfold (mm)                      .                      Not able to take

## **Section A: General Health**

*This first section asks about you and your baby's general health.*

**1. I would now like to ask you about your health. How would you describe your own health generally? Would you say it is...**

Excellent       Very Good       Good       Fair       Poor

**2. I would now like to ask you about your child's health. How would you describe his/her general health? Would you say it is...**

Excellent       Very Good       Good       Fair       Poor

## **Section B: Childcare**

*This next section asks about any childcare arrangements you may have for your (child's name)*

**1. Have there been any changes to your regular childcare arrangements since our last visit?**

Yes       No

If Yes or don't know, go to question B2. If no go to section C.

**2. Have you ever made any regular arrangement for your baby to be looked after, either while you are at work or for any other reason? By regular we mean an arrangement that normally runs for at least five hours a week and has lasted for at least one month.**

Yes             No

Please tell us about your *current* arrangements:

	How many hours per week on average?	Is your child looked after in your own home?		Does the carer feed your child?	
		<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
(a) Husband/wife/partner .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Child's non-resident parent .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Your mother .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Your father .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Your partner's mother .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Your partner's father .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Child's non-resident father's/mother's mother .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Child's non-resident father's/mother's father .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Other relative .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Friends/neighbours .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Live-in nanny/au pair .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Other nanny/au pair .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(m) Registered childminder .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(n) Unregistered childminder .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(o) Workplace/college nursery/crèche .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(p) Local authority day nursery/crèche .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(q) Private day nursery/crèche .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(r) Other, specify .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

.....

## **Section C: Childhood illnesses**

*We would like to know about any health problems (child's name) has been taken to the GP surgery for. How many separate health problems, if any, has (child's name) had, not counting any accidents or injuries?*

### **1. Has (child's name) seen a doctor or nurse since he/she was 6 months old because he/she had a problem you were worried about?**

Yes       No       Don't know       Refused to answer

**Interviewer:** If NO, don't know or refused go to question C4

### **2. How many times?**

Once       Twice       3-4 times       5 – 10 times  
 11 or more times       Don't know       Refused to answer

### **3. What was the reason for the visit? (Cross ALL that apply)**

<u>Reason</u>	Saw a doctor		Saw a nurse	
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
Tummy upset/wind/colic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snuffles/cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thrush	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not gaining enough weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gaining too much weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If other, please describe .....

**4. Has (child's name) been given any medical diagnosis?**

- Yes       No

**If yes, please give details**

- (a) .....
- (b) .....
- (c) .....
- (d) .....

**5. Has (child's name) been admitted to hospital since he/she was 6 months old? (Child must have been in hospital for at least 24 hours).**

- Yes       No       Don't know       Refused to answer

**5a. If yes, how many times? .....**

**6. Has (child's name) been to a hospital outpatient clinic since he/she was 6 months old?**

- Yes       No       Don't know       Refused to answer

**6a. If yes, how many times? .....**

**7. Since birth, has (child's name) been hurt, injured or had an accident and needed medical attention from a doctor or hospital?**

- Yes       No       Don't know       Refused to answer

**7a. If yes, how many times? .....**

**Section D: Sleep**

*We are also interest in how many hours (child's name) is sleeping throughout the day and night.*

**How many hours on average does (child's name) sleep in 24 hours? This includes any naps in a baby chair/buggy etc?**

- 1a. Day (6am to 6pm) .....  Not applicable
- 1b. Night (6pm to 6am) .....  Not applicable

**Section E: Food frequency questionnaire**

*I am now going to ask you about the breast milk your baby has had in the past 4 weeks.*

**1. Not including expressed breast milk, can you tell me how many days out of the past 4 weeks (28 days) was (child's name) breast fed?**

Number of days .....  Not applicable

**Interviewer:** If answers zero days go to question F4.  
If answers one or more, please complete questions F2, F3 and F4.

**2. On average, how many feeds per day did (child's name) receive on these days?**

Number of feeds .....

**3. How long on average was (child's name) actively sucking per day on these days?**

Hours ..... Minutes .....

**4. In the past 4 weeks did (child's name) have any expressed milk?**

Yes  No

**Interviewer:** If answers Yes complete questions F5, F6 and F7

**5. How many days out of the past 4 weeks (28days) did (child's name) have expressed milk?**

Number of days .....

**6. On average, how many times per day did (child's name) have expressed milk on these days?**

Number of times per day .....

**7. What was the average amount of milk per day on these days?**

Quantity (ml) ..... **Interviewer:** 1 oz = 30 mls







**13** \*Did your baby eat any jars, tins or pots of baby foods in the past 4 weeks?

Yes                       No

If answers No go to question E20

		Did your baby eat the following foods?		Brand	Frequency								Times per day	Average no. of jars on each occasion	
		Yes	No		Never	1-3 per month	Number of days per week								
							1	2	3	4	5	6			7
<b>14</b>	Breakfast meals such as porridge														
<b>15</b>	Meat or fish-based meals														
<b>16</b>	Vegetable, pasta or rice-based savoury meals														
<b>17</b>	Milk or cereal-based desserts														
<b>18</b>	Fruit-based desserts, not including pure fruit puree														
<b>19</b>	Pure fruit puree														

		Frequency									Times per day	Average amount per serving
		Never	1-3 per month	Number of days per week								
				1	2	3	4	5	6	7		
<b>Bread and crackers</b>												
20	White bread											No. of slices
21	Brown and wholemeal bread											No. of slices
22	Crackers, cheese biscuits and breadsticks											No. of crackers
23	Chapattis made with white flour											No. of pieces
24	Chapattis made with wholemeal flour											No. of pieces
<b>Breakfast cereal</b>												
25	Breakfast cereals and porridge*											No. of dsp dried 1 Weetabix = 6
26	What are the main types of cereal used?	Type									Brand	
		Type									Brand	
		Type									Brand	
<b>Potatoes, rice and pasta</b>												
27	Boiled and baked potatoes											No. of egg size potatoes = 1 1 av. scoop (1/4 cup) = 1
28	Chips, potato shapes and roast potatoes											McDonald's = 2 1 waffle or 2 croq. = 1
29	Boiled rice											No. of dsp cooked
30	Fried rice, pilau, biryani											No. of dsp cooked
31	Pasta											No. of dsp cooked
<b>Meat and fish</b>												
32	Chicken or turkey in batter or breadcrumbs											1 nugget = 0.5; 1 stick = 1 1 burger = 3
33	Beef burgers, including Halal beef burgers											1 burger = 4
34	Bacon and gammon											1 rasher back/streaky = 1 1 whole rasher = 2
35	Sausages, including Halal sausages											1 thin chipolata = 1 1 large = 2

		Frequency									Times per day	Average amount per serving
		Never	1-3 per month	Number of days per week								
				1	2	3	4	5	6	7		
36	Meat casseroles, stews and curries											No of dessert spoons (not incl. potato topping)
37	Roast, grilled or fried meat, including kebabs											Chicken breast = 4 Average slice = 1
38	Liver, kidney and faggots											Faggot = 4 See drawing
39	Meat pies and sausage rolls											Individual meat pie = 4 See drawing
40	Ham and processed cold meats											Average slice = 1 See drawing
41	Fish in batter or breadcrumbs											Fish finger = 1 Triangle shape = 3 Chip shop fish = 5
42	Other white fish											See drawing 6 dsp = 1
43	Oily fish, e.g. tuna, salmon, mackerel											No. of dessert spoons Std can tuna = 17
<b>Vegetables</b>												
44	Tinned peas, carrots, sweet corn and mixed vegetables											No. of dessert spoons
45	Carrots											No. of dessert spoons
46	Peas and green beans											No. of dessert spoons
47	Sweetcorn (fresh)											No. of dessert spoons
48	Broccoli, cabbage, spring greens and brussel sprouts											No. of dessert spoons
49	Cauliflower											No of dessert spoons
50	Tomatoes											1 dsp tinned = 0.5 Medium tomato = 5
51	Green salad											1 leaf lettuce = 1 3 slices cucumber = 1
52	Beans and pulses											No. of dessert spoons
53	Other vegetables e.g. aubergine, okra											No. of dessert spoons

		Frequency								Times per day	Average amount per serving	
		Never	1-3 per month	Number of days per week								
				1	2	3	4	5	6			7
<b>Other meal items</b>												
54	Vegetarian burgers, sausages and nuggets											1 burger = 2 1 thin saus = 1 1 lg saus = 2 1 nugget = 0.5
55	Pizza											See drawing
56	Quiche and savoury flan											See drawing
57	Eggs											No. of eggs
58	Cheese											1 dsp grated = 0.5; 1 slice (see drawing = 1); 1 dsp cottage = 1 Small triangle = 1
59	Savoury white sauce											No of dessert spoons
<b>Fruit</b>												
60	Tinned fruit											No. of dessert spoons 1 can fruitini = 12 dsp
61	Apples and pears											1 whole fruit = 1 8 dsp cooked fruit = 1
62	Bananas											No. of bananas
63	Oranges and satsumas											Satsuma = 1 Orange = 3
64	Peaches, nectarines, melon											1 peach/nectarine = 3 1 thin slice melon = 1
65	Strawberries, raspberries, mango and kiwi											Kiwi = 1, mango = 3 5 strawberries = 1 15 raspberries = 1
66	Plums, cherries and grapes											Plum = 1 10 cherries/grapes = 1
<b>Desserts</b>												
67	Yoghurt and fromage frais											Weight (grams) Small pot approx 50g Average pot approx 100g

Please tick the box if your child eats any of the following yoghurt or fromage frais products, or describe if there are any other's that are not listed here													
68a) Ordinary whole milk yoghurt and fromage frais <input type="checkbox"/>	68b) Ordinary low-fat yoghurt and fromage frais <input type="checkbox"/>	68c) Danone baby fromage frais made with follow on milk <input type="checkbox"/>	68d) Onky Blok fromage frais with added vitamins <input type="checkbox"/>	68e) Supermarket own brand fromage frais with added vitamins <input type="checkbox"/>	69) Other .....								
			Frequency							Times per day	Average amount per serving		
			Never	1-3 per month	Number of days per week								
							1	2	3	4	5	6	7
<b>Desserts continued</b>													
70	Other ready-made desserts in pots												Average pot = 1
71	Ice-cream												No. of dessert spoons Mini milk = 3 1 scoop = 6
72	Custard and sweet white sauce												No of dessert spoons
73	Halva (semolina or carrot)												No of dessert spoons
74	Milk puddings e.g. rice puddings, rasmalai												No of dessert spoons
75	Other puddings, e.g. sponge puddings, fruit pies												No of dessert spoons
<b>Cakes, biscuits and snacks</b>													
76	Cakes, buns and pastries												Small cake e.g. mini-roll = 1 Bun/scone = 2
77	Chocolate and digestive biscuits												Chocolate finger = 1/2 Digestive size = 1 Wrapped biscuit = 2
78	Other biscuits												No. of average biscuits
79	Chocolate												Fun/treat size Mars etc = 1 3 squares chocolate = 1 Average bag buttons = 2
80	Sweets												Fun size bag = 1 Average size bag = 2
81	Crisps and savoury snacks												1 average bag = 1

Spreads												
82	Marmite and Bovril											No. of teaspoons 1 sl bread = 0.3 tsp
83	Peanut butter											No. of teaspoons 1 sl bread = 2 tsp
84	Jam and sweet spreads											No. of teaspoons 1 sl bread = 2 tsp
85	Butter and margarine											No. of teaspoons 1 sl bread = 1.5 tsp
Miscellaneous												
86	Sugar											No. of teaspoons
Drinks												
87	Baby juices											
88	Pure fruit juice											
89	Fruit drinks											
90	Ribena, C-vit and high juice blackcurrant squash <i>(amt. diluted)</i>											
Please choose the main type of blackcurrant squash your child drinks, or describe if there are any other's that are not listed here												
91a) Ordinary Ribena, C-vit and high juice  <input type="checkbox"/>		91b) Ribena Really Light  <input type="checkbox"/>		91c) Low sugar high juice  <input type="checkbox"/>				92) Other ..... .....  <input type="checkbox"/>				

		Frequency									Times per day	Average amount per serving
		Never	1-3 per month	Number of days per week								
				1	2	3	4	5	6	7		
<b>Drinks continued</b>												
93	Squash, not including low cal ( <i>amt. diluted</i> )											
94	Low cal squash ( <i>amt. diluted</i> )											
95	Fizzy drink, not including low cal											
96	Low calorie fizzy drinks											
97	Tea ( <i>amt. without milk</i> )											
98	Water											
Main type of milk used		Brand/type	Frequency							Times per day	Average amount per serving (oz)	
			Never	1-3 per month	Number of days per week							
				1	2	3	4	5	6	7		
99	Cow's milk	<input type="checkbox"/> Whole/full fat <input type="checkbox"/> Semi-skimmed <input type="checkbox"/> Skimmed <input type="checkbox"/> 1% fat										
100	Goat's milk	<input type="checkbox"/> Whole/full fat <input type="checkbox"/> Semi-skimmed <input type="checkbox"/> Skimmed										
101	Soya milk	<input type="checkbox"/> Original <input type="checkbox"/> Light <input type="checkbox"/> Sweetened <input type="checkbox"/> Unsweetened										
102	Formula milk	<input type="checkbox"/> Cow and Gate <input type="checkbox"/> Milupa <input type="checkbox"/> Aptamil <input type="checkbox"/> SMA <input type="checkbox"/> HiPP Organic <input type="checkbox"/> Heinz <input type="checkbox"/> Farleys <input type="checkbox"/> Other .....										



			Frequency								Times per day	Average amount per serving	
			Never	1-3 per month	Number of days per week								
					1	2	3	4	5	6			7
103	Soya Formula	<input type="checkbox"/> Cow and Gate <input type="checkbox"/> Milupa <input type="checkbox"/> Aptamil <input type="checkbox"/> SMA <input type="checkbox"/> HiPP Organic <input type="checkbox"/> Heinz <input type="checkbox"/> Farleys <input type="checkbox"/> Other .....											
<b>Other foods and drinks</b>													
104	Other												

**Section F: Screen time**

**1. How many hours per day on average is your television on at home (you don't have to be watching it)?**

Weekdays .....  Not applicable

Weekends .....  Not applicable

**2. Over the last month, on average how many hours per day did you watch TV or DVDs?**

	None	Less than 1 hour a day	1 to 2 hours a day	2-3 hours a day	3-4 hours a day	More than 4 hours a day
(a) Week day: before 6pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Week day: after 6pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Weekend: before 6pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Weekend: after 6pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3. Over the last months, on average how many hours per day does (child's name) watch TV or DVDs?**

	None	Less than 1 hour a day	1 to 2 hours a day	2-3 hours a day	3-4 hours a day	More than 4 hours a day
(a) Week day: before 6pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Week day: after 6pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Weekend: before 6pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Weekend: after 6pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## **Section G: Physical activity**

The next questions are about any physical activities you may have done in the last week.

- 1. In the last week, how many times have your walked *continuously*, for at least 10 minutes, for recreation, exercise or to get to or from places?**

Number of times: .....  Not applicable

**Interviewer:** stress that this must be **continuous walking**, i.e. for at least 10 minute without stopping

- 2. What do you estimate was the total time that you spent walking in this way in the last week?**

Minutes ..... Hours .....

**Interviewer:** If the respondent appears to behaving difficulty in totaling the time over the entire week, you could assist by prompting for a time each day and adding them yourself, e.g. 'Did you walk on Monday? For how long did you spend walking on Monday? And did you walk on Tuesday? For how long?'

- 3. In the last week, how many times did you do any vigorous gardening or heavy work *around the yard* which made you breathe harder or puff and pant e.g. heavy digging, landscaping?**

Number of times: .....  Not applicable

**Interviewer:** The types of activities which may be included in this section could include heavy digging, tree lopping, landscaping (e.g. pushing a wheelbarrow or moving large rocks) pushing a lawn mower and using a hand saw.

- 4. What do you estimate was the total time that you spent doing vigorous gardening or heavy work *around the yard* in the last week?**

Minutes ..... Hours .....

**Interviewer:** As for the walking question, if the respondent is having trouble providing a total time, assist them by prompting for a time each day.

The next questions exclude household chores, gardening or *yard work*

5. In the last week, how many times did you do any vigorous physical activity which made you breathe harder or puff and pant e.g. jogging, cycling, aerobics, competitive tennis?

Number of times: .....  Not applicable

**Interviewer:** The types of activities which might be reported here, in addition to the above examples include football (off all types), hockey, squash, cross-country skiing, cross-country hiking (i.e. in rough terrain, netball, gymnastics, using a rowing machine, martial arts, high – impact and step aerobics).

6. What do you estimate was the total time that you spent doing this vigorous physical activity in the last week?

Minutes ..... Hours .....

7. In the last week, how many times did you do any other more moderate physical activities that you have not already mentioned e.g. gentle swimming, social tennis, golf?

Number of times: .....  Not applicable

8. What do you estimate was the total time that you spent doing these activities in the last week?

Minutes ..... Hours .....

9. To what extent do you agree or disagree with the following statements about physical activity and health?

(a) Taking the stairs at work or generally being more active for at least 30 minutes each day is enough to improve your health.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(b) Half an hour of brisk walking on most days is enough to improve your health.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(c) To improve your health it is essential for you to do vigorous exercise for at least 20 minutes each time, three times a week.

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

**(d) Exercise doesn't have to be done all at one time—blocks of 10 minutes are okay.**

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

**(d) Moderate exercise that increases your heart rate slightly can improve your health.**

Strongly disagree

Disagree

Neither agree nor disagree

Agree

Strongly agree

## Section H: Parent's diet – Short Form Food Frequency Questionnaire

The following questions ask about some foods & drinks you might have during a 'typical' week, over the past month or so. Do not be concerned if some things you eat or drink are not mentioned. **Please cross how often you eat at least ONE portion of the following foods & drinks:** (a portion includes: a handful of grapes, an orange, a serving of carrots, a side salad, a slice of bread, a glass of pop).

Please only put one cross, but answer every line.

	Rarely /never	Less than once a week	Once a week	2-3 times a week	4-6 times a week	1-2 times a day	3-4 times a day	5+ a day
1a. Fruit (tinned/fresh)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1b. Salad (not garnishes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1c. Vegetables (tinned/frozen/fresh but not potatoes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1d. Boiled, mashed or jacket potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1e. Fried or roasted potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1f. Oven-cooked chips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1g. Fried chips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1h. Fried rice/biriyani	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1i. Chapattis/parathas/puris/naan with butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1j. Boiled rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1k. Chapattis/parathas/puris/naan without butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Snacks</b>								
2a. Biscuits (chocolate, plain, savoury)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2b. Cakes, pastries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2c. Crisps/other savoury snacks e.g. Doritos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2d. Chevda, Bombay mix etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2e. Indian sweets e.g. burfi, jelabi, gulab jaman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2f. Samosas, pakoras, spring rolls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Rarely /never	Less than once a week	Once a week	2-3 times a week	4-6 times a week	1-2 times a day	3-4 times a day	5+ a day
2g. Sausage rolls, pork pies, pasties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2h. Other snacks Specify.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Drinks</b>								
3a. Natural fruit juice e.g. orange, pineapple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3b. Mango juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3c. Fruit drinks, squash – sugar-free	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3d. Fruit drinks, squash – containing sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3e. Coke/Pepsi/Fanta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3f. Diet Coke/Pepsi/Fanta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Supermarket ready meals/Take-away/Chip shop</b>								
4a. Meat pies, pasties, vegetarian pies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4b. Pizza, quiche, flan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4c. Chip-shop meal e.g. fish, chips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4e. Beef burgers, veggie burgers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4f. Fried chicken take-away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4g. Indian take-away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4h. Donner kebab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4i. Chinese take-away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4j. Other ready meal/take-away meal Specify.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## **Section I: General Health Questionnaire (28 item)**

**Please read this carefully:**

We should like to know if you have had any medical complaints, and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past. It is important that you try to answer ALL the questions. Thank you very much for your co-operation.

Have you recently:

1	Been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
2	Been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
3	Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
4	Felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
5	Been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
6	Been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
7	Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
8	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
9	Had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
10	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
11	Been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
12	Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
13	Found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
14	Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual



15	Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
16	Been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
17	Felt on the whole you were doing things well?	Better than usual	About the same as usual	Less well than usual	Much less well
18	Been satisfied with the way you've carried out your task?	More satisfied	About the same as usual	Less satisfied than usual	Much less satisfied
19	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less than usual
20	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
21	Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
22	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
23	Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
24	Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
25	Thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
26	Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
27	Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
28	Found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

## **Section J: Foods in your home**

Please tell us whether you have had any of the following foods or drinks in your home over the past 7 days. Estimate the amount of food based on the greatest amount that you had in your home in that period. **Remember: There is no right or wrong answer.**

**Interviewer Note:** Use the pictures on the guidance sheet to help you work out the sizes. There are also tips at the bottom of the table to help you decide how much you have of each item.

Food / Drink	Description	Size	Amount			
<b>Fruits</b>						
1. Bananas	Fresh	Individual	0	1-3	4-10	More than 10
2. Apples	Fresh	Individual	0	1-3	4-10	More than 10
3. Melon	Fresh	Whole melon	0	1/2	1	More than 10
4. Grapes	Fresh	Handful	0	1-3	4-10	More than 10
5. Oranges	Fresh	Individual	0	1-3	4-10	More than 10
6. Pears	Fresh	Individual	0	1-3	4-10	More than 10
7. Peaches	Fresh	Individual	0	1-3	4-10	More than 10
8. Canned fruit in syrup	Any fruit	Medium sized can	0	1 can	2-5	More than 5
9. Canned fruit in juice/ water	Any fruit	medium sized can	0	1 can	2-5	More than 5
10. Plums	Fresh	Individual	0	1-3	4-10	More than 10
11. Kiwis	Fresh	Individual	0	1-3	4-10	More than 10
12. Pineapple	Fresh	Whole pineapple	0	1/2	1	More than 1
13. Berries or cherries (including strawberries)	Fresh or frozen	Handful	0	1	2	More than 2
14. Grapefruit	Fresh	Whole grapefruit	0	1/2	1-3	More than 3
15. Fruit salad	Fresh	Cup / handful	0	1-3	4-10	More than 10
16. Dried fruit (e.g. raisins, apricots)		Cup / handful	0	1	2	More than 2
<b>Vegetables</b>						
17. Carrots	Fresh or frozen	Individual	0	1-3	4-10	More than 10
18. Celery	Fresh	Individual stick	0	1-3	4-10	More than 10
19. Greens / spinach	Fresh or frozen	Cup / handful	0	1	2	More than 2
20. Lettuce	Fresh	Individual head or mixed bag	0	1	2	More than 2
21. Sweet corn	Fresh or frozen	Cup / handful	0	1	2	More than 2
22. Peas	Fresh or	Cup / handful	0	1	2	More than 2

Food / Drink	Description	Size	Amount			
	frozen					
23. Tomatoes	Fresh	Individual	0	1-3	4-10	More than 2
24. Tomatoes	Canned	Medium can	0	1	2-5	More than 5
25. Broccoli	Fresh or frozen	Florets / head	0	1-3	4-10	More than 10
26. Green beans	Fresh or frozen	Cup / handful	0	1	2	More than 2
27. Cabbage	Fresh	Whole cabbage	0	1/2	1	More than 1
28. Other vegetables like aubergine, okra etc.	Fresh	Cup / handful	0	1/2	1	More than 1
<b>Snacks</b>						
29. Crisps, tortilla chips	All varieties	Handful	0	1-3	4-10	More than 10
30. Salted nuts	Including peanuts	Handful	0	½ - 3	4-10	More than 10
31. Biscuits	All varieties	Medium size pack	0	1-15	16-30	More than 30
32. Sweets	Hard and soft	Handful	0	1	2-5	More than 5
33. Chocolate	All varieties	Medium sized bar or handful	0	1	2-5	More than 5
34. Cakes, muffins	All varieties	Medium portion	0	1-3	4-10	More than 10
35. Ice-cream	All varieties	Medium tub	0	1	2	More than 2
<b>Drinks</b>						
36. Fizzy drink (e.g. cola)	Not diet	Medium can / bottle	0	1-5	6-10	More than 10
37. Fizzy drink (e.g. diet cola)	Diet	Medium can / bottle	0	1-5	6-10	More than 10
38. Sports drink (e.g. Lucozade, Gatorade)	All varieties	Medium bottle	0	1-5	6-10	More than 10
39. Fruit drinks (e.g. Sunny Delight, Ribena)	Not 100% fresh	Medium can / bottle	0	1-5	6-10	More than 10

### Tips for filling out this form

- Individual fruits are single pieces (e.g. 1 apple, 1 banana)
- Individual tomatoes refer to regular size tomatoes. If you have cherry tomatoes, count each one as 2.
- A medium can of coke has 330ml of coke
- 1 handful of crisps is about the same amount as a regular individual sized bag of crisps
- ½ handful of salted nuts is about the same amount as a small individual sized bag of peanuts



2 broccoli florets



1 handful grapes



1 medium banana



1 cup (about the size of a man's fist)



1 medium can



1 cup of peas



1 medium can of fizzy drink



Medium sized pack of biscuits



1 medium muffin